

County of San Diego
Low Income Health Program (LIHP)

SERVICE AUTHORIZATION FORM INSTRUCTIONS
For In-person Interpreter Services

LIHP Enrollee Interpreter Services Form – Access and Authorization Instructions

Instructions:

The purpose of the Service Authorization Form (SAF) is to confirm with the requesting clinic that in-person or in-person American Sign Language (ASL) interpreting service has been arranged at the clinic's request for a LIHP enrollee. The LIHP provider clinic will utilize this form for verification that authorized, scheduled, interpreting services were provided **OR** canceled, and when they were canceled. This form will also be used for ensuring appropriate payment for interpreter services for the LIHP.

Clinics **MUST complete Section B** of the SAF once interpreting service is provided or canceled, and fax the form back to the LIHP at 855-394-7927.

Instructions for the Clinics for Completing Section B:

- If services were provided: provide the service date, actual start time, actual end time, and the name of the interpreter.
- If services were canceled: provide the date and time that the service request was canceled.
- Provide your initials and date to indicate that you verify the information in Section B is accurate.
- FAX the SAF with Section B completed to the Administrative Service Organization (ASO) for the LIHP at 855-394-7927.

NOTE: It is an expectation that all programs will make every effort to develop bilingual/bicultural staff to reflect the population they serve. In this way, services will be delivered in a culturally competent manner, in the client's preferred language, and interpreter services will be utilized more efficiently by everyone.

IMPORTANT: Providers are requested to CANCEL any scheduled interpreter services that are not needed by contacting the ASO at 858-658-8650 immediately after it is determined that the services will not be needed. Services must be canceled at least 48 hours in advance, or it will still be billed to the LIHP; however, notification of all canceled services must be made.

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SERVICE AUTHORIZATION FORM

LIHP Enrollee Interpreter Service Form – Access and Authorization Form

Instructions:

1. **ASO:** To request interpreter services, please complete Client Information, Service Information Section A, Requester Information, and then sign. Fax completed form to the selected interpreter service provider **AND** the requesting clinic.
2. **CLINICS:** Complete Service Information **Section B** after services have been provided or canceled, and fax the form back to the LIHP ASO, 855-394-7927. This form **MUST** be faxed back for the purpose of payment.

Please “X” the Provider Selected:

	<u>Service Provider:</u>	<u>Phone:</u>	<u>Fax#:</u>	<u>Type of Interpreting:</u>
<input type="checkbox"/>	Interpreters Unlimited	800-726-9891	800-726-9822	Oral/Spoken, In-person
<input type="checkbox"/>	Deaf Community Serv. of SD, Inc.	619-398-2488	619-398-2490	American Sign Language

Client Information:

The County of San Diego, LIHP has authorized the following interpreting service for:

Client Name: _____ Date of Birth: _____

LIHP Enrollee #: _____ Eligibility Dates: _____

Language Requested: _____ Nature of Appointment: _____

Service Information:

Section A:			Section B:			
Date:	Requested:		Actual:		Interpreter's Name: (If Services were canceled, please write "Canceled")	Verified By: (Initial Date)
	Start Time	End Time	Start Time	End Time		

Requester Information:

Requester:

- Name: _____
- Phone: _____
- Fax: _____
- Agency Name: _____

Manager/Designee Approved By:

(Print Name) (Date)

(Signature) (Date)

Service Address: _____

Site Contact:

Name: _____

Phone Number (if different): _____